

# **A Special Interview with Dr. Meryl Nass**

By Dr. Joseph Mercola

**DM: Dr. Joseph Mercola**

**MN: Dr. Meryl Nass**

Introduction:

**DM:** Welcome, everyone. This is Dr. Mercola, and today I am joined by Dr. Meryl Nass, who is a physician in Bar Harbor, Maine. Her work includes investigating anthrax disease and anthrax vaccines. She studied many different vaccines and written about them and the diseases they're supposed to prevent since 2007. Some of her most recent writings address the seriousness of the bacterial adaptations due to vaccines. So, welcome and thank you for joining us today, Dr. Nass.

**MN:** Thanks for inviting me.

**DM:** All right. Let's start with the first question. In the context of vaccines, I'm wondering if you could explain what this bacterial adaptation is, and how vaccines cause bacteria not only to mutate, but to become antibiotic-resistant.

**MN:** The pneumococcal conjugate vaccine was introduced into the United States in 2000. It was meant to address diseases caused by *Streptococcus pneumoniae* in small children. The vaccine was given as a three- or four-dose series at two months, four months, six months, and approximately 12 to 15 months.

Subsequently, that vaccine was stopped, and a newer vaccine, a newer Prevnar with 13 serotypes instead of seven, was initiated in the United States [and] licensed in 2010. Now children are receiving that vaccine instead.

Now, the reason for that was that when the Prevnar was originally introduced, it seemed to cause a reduction in cases of meningitis, and possibly pneumonia, due to the bacteria that were included in the vaccine. Subsequently, there was an increase in cases throughout in the United States and also in the rest of the world of strains that were not included in the vaccine.

There have been a lot of studies on this. In some places, there are more infections than before. In most places, there seems to be net fewer, but not a lot net fewer. The infections that now occur – not everywhere, but it seems that in the majority of places – are more antibiotic-resistant than they were before.

Now, that's a problem in the U.S. [But] that is a much bigger problem in places like India. In India, it costs about 75 cents to inoculate a child with all the childhood vaccines that were commonly used – 75 cents for one child, all the vaccines. And yet half of India has not inoculated their children, because they can't afford 75 cents. The Prevnar vaccine costs 108 dollars a dose.

**DM:** And how many doses are required?

**MN:** Four now are required.

**DM:** So, well over 500 dollars.

**MN:** Right. Five hundred dollars in the U.S. In India, [it's] a little less, but it's still way more than they can afford. Adding Prevnar has increased the cost of vaccinating children twenty-fold in India.

What happens in India is that if public health money is spent on Prevnar (which it is, because Prevnar is being pushed by WHO, GAVI, and other organizations that are vaccine proponents and are interested in saving lives), there may be a shift to even fewer children getting the standard vaccines.

But in addition, there's even a bigger problem, because children who got, for instance, pneumonia in India could be treated for one dollar. The cost of the WHO-recommended antibiotics for childhood pneumonia costs a dollar. But now with increased antibiotic resistance, many of these children are requiring antibiotics that costs 100 dollars. This has led to a significant problem in the Third World. That's enough on that, I guess.

**DM:** Well, it's kind of challenging, too. I mean, the reason this vaccine is being given is to prevent an infection, a bacterial infection. We know that the best way to prevent bacterial infections is not with a vaccine, but to build up your natural immunity. And one of the most powerful ways you can do that is by improving the quality of the food that you're eating.

Now, in India, of course, it's not so much of a challenge with processed foods. It's really an issue of getting enough calories and enough good food in. But once they do that, they're going to be far more resistant to disease than if they even had this vaccine. It would seem it would be a more effective strategy to improve the nutrition of the population. Not only would you prevent pneumonia, but you'd prevent all these other chronic degenerative disease, improve their intelligence, and their ability to enjoy life in the full vitality.

It seems really a seriously misguided effort and massive waste of funding to encourage this type of intervention.

**MN:** I entirely agree. I'll show you – this is actually from CDC – this graph.

**DM:** What does that represent?

**MN:** What it shows is that, in fact, it looks as if the pneumonia hospitalizations in children under two [years old], which is at the top of the graph, were reduced.

**DM:** On the top?

**MN:** [Pneumonia hospitalizations] in children under two were reduced with Prevnar. But for children aged two to four, there was no reduction even after they all received it. These are years on the bottom.

**DM:** So, the horizontal one are the years going forward, and the vertical graph is the amount of admissions.

**MN:** Right. This is the rate of pneumonia hospitalizations – all because of pneumonia hospitalizations. It appears that the vaccine did not, at any point, reduce pneumonia infections in the children greater than two years old. It probably doesn't even work for very long. It's probably not a terribly effective vaccine.

**DM:** All right. Can you give us some examples in the medical literature of these vaccine bacterial adaptations that are affecting us right now?

**MN:** Yes. In this particular case, in the United States, ear infections and sinus infections (with ear infections, we're about 50 percent due to *Strep pneumoniae*) have become much harder to treat, because there are more episodes of drug resistance. That is due to a combination of things that happened that have been attributed to the Prevnar vaccine but may also be influenced by the amount of antibiotics used in animal feed, and possibly by overprescribing of antibiotics by doctors.

However, 80 percent of antibiotics in the U.S. is put into animal feed. Only 20 percent are prescribed for humans. And some numbers are prescribed by veterinarians for animals. Even though doctors have been blamed for the increase in antibiotic-resistant strains of bacteria, overall they are responsible for only a minority of the antibiotics prescribed, and are probably not that responsible for the epidemic of antibiotic resistance.

In fact, FDA finally stepped in this past year, and told farmers they should no longer give fluoroquinolones indiscriminately to their animals, because fluoroquinolones develop resistance very easily with one mutation and were considered a drug that was used as a second-line when the first-line antibiotics were no longer effective. FDA is hoping that this will improve the ability of fluoroquinolones to work for infections such as sinus infections and [inaudible 9:01].

Anyway, what happened in the U.S. is that [inaudible 9:08] and sinus infections have become much harder to treat in the 12 years since Prevnar was first licensed.

On the one hand, certain strains of *Strep pneumoniae* that were present, but not in large quantity, have increased in number. They are now colonizing people at a much higher rate.

The other thing that happened is that bacteria that also caused these infections, like *Haemophilus influenzae* (which tend to add a lot of antibiotic resistance even before Prevnar has come into this niche), may have been created by reducing the number of strains that were covered by the original Prevnar vaccine, that now more of the sinus infections and more of the [inaudible 10:02] are due to *Haemophilus pneumoniae*, and about 40 percent of those are drug-resistant.

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Fewer infections are due to *Strep pneumoniae*. But of those fewer, an increased proportion tends to be drug-resistant, that doctors have to use stronger antibiotics (which is exactly what we've been told for so many years that we're not supposed to do, because it can increase drug resistance) and we have higher rate of failures of treatment.

Now there've been papers published about kids with [inaudible10:38] who could not be treated with antibiotics could only be treated with surgery – making a hole in the eardrums, so that they could drain pus that way, because antibiotics didn't work. I personally have had more cases of sinus infections that required two or three courses of antibiotics.

**DM:** That's a really good illustration of that.

Now that the GMO initiative is over in California, we're seeking to actually put our efforts and energies for the coming year in the CAFOs, the concentrated animal feeding operations. By really making an impact (I think we're going to be targeting California) and requiring the labeling of these, that there'll be a massive decrease in these operations.

Almost all the CAFO operations require or mandate that they use these antibiotics, and all these federal regulatory agencies make these recommendations. It's all fine and well, but none of the massive international or multinational corporations are required to implement them.

**MN:** Exactly.

**DM:** Ultimately, we need a reduction, massive reductions, because as you mentioned, probably 85 percent of the antibiotic usage is directed toward the animals. We have to address it at that level. I mean, it's certainly useful for physicians to be discriminate and wise, but we could have a hundred percent compliance in the physicians and that wouldn't put a dent in the problem.

Now, you had mentioned the problem with ear infections, so let's use that as an illustration. Can you explain why we should be concerned about them becoming antibiotic-resistant, and how these infections will continue to be a problem?

**MN:** Well, another thing that happened... Again, I'm more familiar with sinusitis, because I'm an internist, rather than ear infections.

**DM:** You're not a pediatrician.

**MN:** Right. I'm not really a practitioner. In the case of sinus infections, the Infectious Diseases Society has actually recommended that doctors withhold treatment for mild cases of sinus infections, and recommended that unless the patient is having fever or gross pus, you should not treat.

I think this good and bad. I think we do overtreat with antibiotics certainly. But I think that the reason that we've been instructed now not to treat is that the problem of drug resistance has become so severe that the guideline writers are hoping that by using fewer antibiotics – doctors using fewer antibiotics, not farmers – the problem will abate to some extent. That is wishful thinking, because there really isn't any evidence that that will happen.

It also means that your patients are very unhappy with you if you actually try and implement the guidelines and say, "Look, you've got a sinus infection," or "Maybe you have a sinus infection..." (I say that because it can be hard to diagnose a sinus infection for certain) "...but the guidelines tell me not to treat you with antibiotics."

Well, people are usually miserable with their sinus infections. It makes them tired. It gives them headaches. They usually can't go to work. And so, they're not very happy with the doctor if the doctor refuses to treat [them].

Now, sure, I think treating with vitamin D is a good idea. Treating with non-antibiotics such as, in some cases, decongestants, antihistamines, or other things, are useful. But sinus infections are bacterial infections. They create pus and, in most cases, you (at least an adult) need to use an antibiotic.

The fact that I now have much fewer options for treating, and the antibiotics that I must use now for sinus infections in adults have a lot more side effects potentially than they did before is a problem for me and a problem for the patient.

**DM:** And all the other physicians out there who are seeking provide that type of care. It is a challenge. We're having this discussion primarily as a result of the side effects or the complications of vaccines that are virtually never mentioned in the literature, media, or when you go into the doctor's office to get your vaccines – this process of developing this bacterial adaptation and then the secondary increased resistance to antibiotics.

You had mentioned sinusitis and ear infections. Are there any other diseases or chronic infections that you believe have increased as a result of this bacterial adaptation secondary to vaccine use?

**MN:** Okay. I'm not sure. Let me say that in the literature, it's been noted that there's been strain replacement for whooping cough (*Bordetella pertussis*), *Neisseria meningitidis* (which is the organism that causes a lot of meningitis), and *Haemophilus influenzae*. And there have been articles about the potential problems with new vaccines and development for tuberculosis, and whether they will cause strain replacement.

I think that what's happened just basically. This is a new problem that was identified first in the last 10 years. It's been studied reasonably well for Prevnar and for *Strep pneumoniae*. It hasn't been studied as well for all the other vaccines and other infections. Even for *Strep pneumoniae*, it's hard to... We can look back and say what happened, but what we can't do is predict what will happen with the new Prevnar 13 vaccine or other potential pneumococcal conjugate vaccines that are in development.

We don't really understand whether we can identify what's happening now [or not]. But we can't predict what's going to happen in the future. We can bring new vaccines in, but we don't know what effect they'll have on the ecology of diseases in the future. And I think it's something that needs to be looked at much more carefully before we license vaccines.

If you'll allow me, I want to switch a little bit to what the kinds of data were used when Prevnar was licensed.

**DM:** Sure.

**MN:** Prevnar was licensed with a big clinical trial conducted at Kaiser in Northern California with 38,000 children. Half received the Prevnar 7 vaccine, and half received an experimental vaccine for *Neisseria meningitidis* type C – type C meningococcal vaccine.

Now, that seemed a little odd to me. I mean, the control was another vaccine. That's a problem. But that's pretty common, because you don't really know what the side effect profile is if you compare one vaccine to another, because each causes side effects. You don't have an inert placebo for comparison.

**DM:** Yeah. That's another trick that these vaccine companies use. They actually use as a control another vaccine, which has similar types of toxic additives. When you compare the differences between the two groups, you don't see a difference, because they're both toxic. I mean, it's a brilliant strategy. They don't use an inert substitute like a saline injection.

**MN:** Right. It's a very interesting strategy. But in this case, they didn't even take a licensed vaccine, but they took an experimental vaccine as their comparator. The experimental vaccine has never subsequently been licensed in the U.S. So, there is no real understanding. There is no published list of what the side effects are for that experimental vaccine. We don't even know what we were comparing it to. Here we had two experimental vaccines being compared to each other. Where is the data? We have no idea really what the safety profile was well.

Now when they're bringing in the Prevnar 13, they compare Prevnar 13 to Prevnar 7 and say, "Well, the side effects are about the same, so it's okay." But we didn't really know what the side effects are for Prevnar 7.

I have to admit that the FDA did notice that.

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When it licensed the drug – the new vaccine... Vaccines are considered drugs by FDA. When it licensed the new vaccine for Prevnar 13 in 2010, it told the company that they needed to conduct additional six studies for safety and efficacy, because they didn't really know how safe the vaccine was and how well it will work.

That's good. But that's also bad, because the company is conducting all the studies. The company decides how to present them, and the company decides how to conduct them. So, whether these studies actually give you an unbiased review of the safety and effectiveness of the vaccine [or not] is open to question. And as you know...

**DM:** I don't think it's open to question at all. I mean, it's just very clear. The person who's funding and conducting the study obviously has a bias. There's a massive conflict of interest. And that's one of the major criticisms of this whole flawed system, that they allow a person who's going to benefit from the introduction of this product – in this case, a vaccine – to do the actual studies rather than have them pay for some outside independent, third-party, objective, and unbiased research to be done to really understand and identify the truth. I mean, the whole system is just fatally flawed.

**MN:** Yes. I totally agree with you. I think it's a crazy system. And it's not going to change anytime soon, because the cost of conducting these studies, even the cost of oversight, is something that the FDA claims it has no funds to do. It doesn't have enough funds to even perform the congressionally mandated inspections.

Most of these products are now getting six-month reviews, which mean the FDA doesn't even have the time to read all the studies that were done in support of licensing them. Anyway, that is going to happen.

In terms of efficacy, how effective is the new vaccine? Well, they said it would be unethical to test it against the placebo, because we've shown that Prevnar is so good at reducing infections in the serotypes it contains. We can't test it against the placebo. We just measure blood levels of antibodies. Our blood levels of antibodies when tested were pretty good, but not that good. In fact, for five of the 13 strains, the blood levels were not up to where they wanted to be. But that has been allowed to pass.

In terms of effectiveness, there was one case report published out of Johns Hopkins which showed that a child that had a very high antibody level to one of the strains in the Prevnar 7 vaccine still got an invasive pneumococcal infection with that strain, despite having a lot of antibodies.

The reason for that is that the antibodies we measure are frequently not the antibodies that are protective. And rarely are actually antibodies that may cause you to be more likely to come down with a disease or have a more severe disease, because they may be blocking the antibodies.

This is an example of how little we know about the things we measure when we bring products into the market. We basically know very little about their safety and their effectiveness when they are first licensed. We learn about them as people use the products.

There was an interesting paradox in how the Prevnar vaccine was licensed. When it was originally licensed, it was said that it didn't really reduce ear infections. It didn't really reduce sinus infections. But what it did reduce were these invasive, very serious, and life-threatening pneumococcal infections, which were primarily pneumonias, bacteremias (which is bacteria in the bloodstream), and meningitis.

Now, think about that for a minute. How can there be a treatment or a preventive medication such as a vaccine that reduces serious infections caused by certain bacteria but doesn't reduce the minor infections caused by the identical bacteria? How can that be? That has been stated over and over. I don't know what it means, but it doesn't make biological sense. I guess that's all I want to say about that.

**DM:** Okay. Do you have any final comments on what we can learn from this, and how we can apply it to some benefit at least? Because it's always useful, from my perspective, to look at these negatives as some positive that we can achieve from, and have a learning experience that we could take away.

**MN:** Well, you've reminded me about something that's kind of unusual but interesting. One takeaway message should be that we must study the ecology of bacterial strains and drug resistance as we introduce new vaccines or new drugs into a population.

Actually, a study to do this was conducted in The Gambia in Africa, where adults and children were given a pneumococcal vaccine. There was a follow-up to see what strains were in the population. People criticized this study. There were several papers and letters to the editor in the literature, saying that it was an unethical study, that the vaccine wasn't intended to provide the

people getting it, particularly the adults, with benefit, because adults have not been shown to have benefit from that vaccine. The people really didn't have explain to them what was being studied.

Here you are taking informed consent from a group of people in Africa who don't know what informed consent is, don't understand anything about different strains or the ecology of bacterial infections, and don't understand what's being studied, but are giving their bodies to be part of this.

Maybe those kinds of studies need to be done in the United States or in the First World in the future. Of course, if you do them, it takes years to watch the effects of these new drugs and new vaccines. And nobody is going to wait that long when the patent clock is ticking to use the drugs.

I think this is just another example of the precautionary principle that's been thrown out the window, and there isn't an easy way to bring it back. We will just suffer the consequences. We will experience whatever happens. We may not even be able to identify what changes are occurring in the patterns of disease as a result of vaccines in particular that are introduced.

Now, this is important also, because so many vaccines, hundreds of vaccines, are in development now. It's possible that huge numbers of vaccines will be brought into clinical practice in the next few years. If that happens, not only do we have no idea how any one individual vaccine may affect the pattern of disease and the pattern of drug resistance, but we have absolutely no idea how the combination of vaccines will affect us. It's something we really need to be observing and collecting information on, as they come into use.

**DM:** Yes. I couldn't agree more. This is, of course, a very controversial subject, the administration of vaccines. Most people viewing this will have some skepticism, and rightly so. But the average person in the United States or, for that matter, most of the world has been convinced – or I would say a better term might be “manipulated” – that there is overwhelming benefit from these vaccines. They just essentially unquestionably accept the recommendation from the media and their physicians.

And really, one of the purposes of this site is to encourage people to exercise some caution, do their due diligence, and to explore all the sides – both sides – because the media and their physicians will almost universally only provide one side of the equation. You really need to do your due diligence to protect yourself from the potential side effects of these interventions. They are significant. They are serious. They are not necessarily all the benefits that are being purported to be by the conventional authority.

A great resource that we recommend and advise people to help them in this process to evaluate the risk and the benefits and make a decision would be NVIC.org (National Vaccine Information Center). Of course, you're associated with them (and have been for some time) and work with Barbara Loe-Fisher. That's a great resource. I think it's really helpful to use this information to help us reconsider our position on these vaccines, and hopefully provide a wider perspective of the potential side effects and consequences.

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So, I want to thank you for joining us. And thank you for helping us better understand the side effects, these bacterial adaptations that occur as a result of using this type of intervention and the consequences of that.

Maybe there are some better strategies by focusing on the foods that we eat and the lifestyles that we have to improve our immune system, rather than to rely on this synthetic intervention that purportedly will immunize us from disease, when I think, in most cases, the reality is nothing can be further from the truth.

*[END]*